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ABSTRACT

The negotiating relationship of a medical school and a community-based organization is examined, based on the point of view of a negotiator and the California Area Health Education Center (AHEC) System model. The Health Professions Educational Assistance Act (1974) funds medical schools to negotiate the use of a portion of their educational resources with specific representatives of medically underserved communities. The goal of the legislation is to improve the distribution, supply, quality, utilization, and efficiency of health care and to encourage the regionalization of educational responsibilities. The negotiation process between the medical school and the AHEC concerns the location and use of some of the educational resources of the medical school to increase the number of primary health care practitioners in the AHEC service area. The legislation defines partially how the medical schools will interrelate with the community. The California AHEC project is based on a cooperative agreement between the University of California Board of Regents and the federal government. Each campus of the University of California system has a specific region within which it must collaborate with one or more AHEC's in the development of reciprocal relationships. The AHEC director, as conciliator, needs to communicate the trading sets of positions effectively and to know the language of medical education and the medical school's constituencies. Reference is made to the following concepts: consensus formation, bargaining field, Prisoner's Dilemma, and the Osgood Proposal. (SW)

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THE ART AND PROCESS OF NEGOTIATION: AN AREA HEALTH EDUCATION CENTER MODEL

"let each man exercise the art he knows."

-Aristophanes

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NOTE

After I had completed this paper I asked J. Philip Loge, M.D., and Malcolm S.M. Watts, M.D. to read and comment on it. They agreed graciously and some of their suggestions have been incorporated in the paper

It is important that the reader note that whenever I refer to AHEC, unless otherwise specified, or AHEC directors, directors, center directors, or chief executive officers, I mean those individuals who are employed by community based organizations which have subcontracted with one of the participating medical schools to achieve the goals of the AHEC legislation.

Introduction

Negotiation is an art that is required in our pluralistic and complex society. It controls international conflicts, staving off nuclear conflagration; settles labor-management disputes; quiets sibling rivalries; and accomplishes a patchwork of other things all of which keeps us civil. The art of negotiation is a process that rewards the practitioner with the satisfaction of achieving highly valued outcomes. The fact that the artful negotiator gains insight into the real and perceived needs of the other negotiator is an important and stabilizing influence in their continuing relationship.

What follows is an analysis of the California Area Health Education Center (AHEC) System from the point of view of a negotiator. The negotiation that is required to make the system work occurs most crucially in the interrelationship between the medical school and the medically underserved communities. I have focused this paper on the role of the AHEC directors and I hope that they and the others with whom they work find this paper helpful.

History of the AHEC Legislation

The AHEC concept can be traced to the Carnegie Commission on Higher Education's special report, Higher Education and the Nation's Health, issued in the fall of 1970. The comprehensive Health Manpower training Act of 1971 shows how strongly that report and its advocates influenced the Congress.

The Health Manpower Training Act of 1971 came under reconsideration in 1975. The House and the Senate committees adopted more specific language than that of the original Act. Both legislative bodies passed the Health Professions Educational Assistance Act (PL 94-484) in 1976. The Senate committee, while considering this Act, described the AHEC concept as a cooperative program involving a school of medicine or osteopathy and a nonprofit public or private area health education center (AHEC).

The California Model

The California AHEC model is a comprehensive expression of the cooperative program envisioned by the Senate. The Statewide staff describes this model as an interrelationship among the medical schools, the AHECs, and the medically underserved communities. "Interrelationship" provides the most accurate one-word description of the AHEC concept because its definition emphasizes reciprocity. The legislation and the rules and regulations require that the medical schools and the AHECs collaborate in the definition of this reciprocity.

The California AHEC project is based on a cooperative agreement between the University of California Board of Regents and the federal government. The University of California, San Francisco School of Medicine is the 'principal investigator' and the source of the memoranda of understanding which integrate the participating UC and private medical schools into a statewide system. Each campus has a specific region within which it must collaborate with one or

more area health education center(s) in the development of reciprocal relationships.

The Negotiated Interrelationship

The AHEC concept is a federal legislative challenge to the town and gown dichotomy of interests. The moment the medical school and the AHEC determine that they want to have an interrelationship defined by the AHEC legislation, a continuing process of negotiation is initiated. This process places the medical school across the table from the AHEC to negotiate the location and the use of some of the educational resources of the medical school toward the goal of increasing the number of primary health care providers in the AHEC service area. The process goal of the AHEC legislation is the negotiation between the town and gown representatives.

It is appropriate that the federal government provided the leadership in raising the question of medical school resource allocation since it has financed medical education so heavily and for so long. In effect, the Congress has offered to fund the medical schools to negotiate the use of a portion of their educational resources with specific representatives of medically underserved communities.

The AHEC legislation delineates its goal as, "Improving the distribution, supply, quality, utilization, and efficiency of health personnel in the health services delivery system and for the purpose of encouraging the regionalization of educational responsibilities

of health professions schools...(Odegaard, 1979)." It specifies its means as the strategic intervention in the education of these providers-in-training and defines the process as negotiation between medical or osteopathic schools and medically underserved communities.

The AHEC Model of Negotiation

> "To enter negotiation implies expectation of a better result from participating than from refraining..."
>
> -Jack Sawyer and Harold Guetzkow
> "The Process of Negotiation"

The process of negotiation may be observed on various levels and at every intersection of power and interests within the California AHEC project. On one level, there is a fair amount of stress among the medical schools based on their collective history and their expectations of the use of AHEC resources. On another level, competition and conflict among the AHECs exist in the system for an assortment of reasons. However, the negotiation most crucial to the realization of the purposes of the legislation takes place between the medical school and the AHEC to specify their contractual interrelationship, including the scope of work which delineates the reciprocation of resources and support (fiscal, human, and political).

The Bargaining Field

Every bargaining situation has what may be termed a bargaining field: "Any point of which represents a state of the joint universe of the bargainers. A value ordering for each bargainer can be placed over the field as before, and, from two value orderings, a conflict set and a trading set of positions can be developed" (Boulding, 1962).

Each negotiating party has a conflict set and a trading set of positions. Trading sets of positions provide the points that are negotiable while the conflict sets of positions have to be avoided if their relationship is to be maintained. It is important to note these trading and conflict sets of positions are defined by sets of values and that both the history of the medical schools and of the medically underserved communities are records of the positions which they have occupied independently. This collective history and the current positions are the bargaining field. When the goal is to negotiate successfully (in 'good faith'), the definition of the bargaining field is a necessary preliminary activity for both negotiators.

The Negotiating Parties

There are characteristics common to every negotiating party. Kenneth Boulding states that the party is an "aggregate or organization that is capable of assuming a number of different positions

while retaining a common identity or boundary" (Boulding, 1962). It is essential that the negotiating parties perceive benefit or, at least, no loss resulting from negotiation; that they recognize there are valued alternative actions that can lead to useful outcomes; and that the parties see each other as having conflicting preferences or opposed interests.

It is important that the negotiators avoid the conflict situation of the 'Prisoner's Dilemma.' In these situations, "Each of two parties must decide either to trust the other and make a friendly move, such as disarming, or to distrust the other and make a hostile move, such as arming. In fact, if a person knows that the other party is making a trusting move it is rational to make a distrustful one, since this will give the first person a great advantage in the situation. Also, if a person knows that the other party is making a distrustful move, it is again rational to make a distrustful one, since this will enable the first person to protect himself. Thus in either event it is 'rational' for each party to distrust the other. Yet both players are worse off if they distrust each other than they would be if they could trust each other - thus the dilemma" (Sawyer, 1974). This dilemma is of concern to us in the California AHEC System because, "In these circumstances distrustful choices are more frequent than trusting ones" (Sawyer, 1974).

The fact that distrust in this case is rational does not mean that it is necessarily productive or successful. A negotiator must resist this dilemma. The Osgood Proposal offers an inducement to trust by graduated reciprocation in tension reduction; that is to say, Osgood proposes, "A set of small, unilateral, conciliatory overtures each preceded by an announcement and carried out without guarantee of reciprocal overtures" (Deutsch, 1977).

The Medical School

> Doctor Foster went to Gloucester.
> In a shower of rain
> He stepped in a puddle, up to his middle
> And never went there again.
>
> Anonymous, 17th Century

Poor Doctor Foster. Had an AHEC been there, possibly he would have been received more warmly. Doctor Foster, without the mud and water, is a composite of the medical school. His problem in Gloucester is analogous to the medical school's problem in medically underserved areas. As the other professional schools, medical schools are dominated by a closed elite network of shared interests and preferences that finds it difficult to negotiate the many puddles that involvement with the poor precipitates.

The AHEC legislation defines the type and minimum amount of involvement of the medical schools creating a range of opportunities that should be satisfactory to the schools and the medically underserved communities; in other words, the legislation defines a significant area of the bargaining field.

The legislation defines partially how the medical schools will interrelate with the community, and prescribes certain short term objectives or outcomes for each party. The medical schools are conscious of their social responsibilities philosophically but their primary orientation, justifiably, is to educate; it is not to provide health care services directly. The fact that medical schools are isolated geographically, politically, racially, and economically from those who have the most dramatic primary health care needs is addressed by the AHEC legislation which stimulates a wider range of alternatives that may be pursued by each negotiating party as a trading set of positions.

The AHEC director should analyze specific problems to be negotiated with the medical school in some detail. The following matrix should be useful.

The Decision Matrix

AHEC ALTERNATIVES / Medical School Alternatives	Hold Out	Compromise
Hold Out	Outcome Utility 0 For AHEC 0 For Medical School	Outcome Utility +10 For Medical School -5 For AHEC
Compromise	Outcome Utility -5 For Medical School +10 For AHEC	Outcome Utility +5 For Medical School +5 For AHEC

The AHEC

> "The millions who are poor in the United States tend to become increasingly invisible....It takes an effort of the intellect and will even to see them."
>
> -Michael Harrington
> The Other America, 1962

The poor are invisible not only to medical schools; this is a conundrum of American life. The Congress has attempted to make the poor visible to the medical schools indirectly. Each AHEC has a board of directors and an advisory council. According to the law, the medically underserved must be represented only on the advisory council which has a full range of responsibilities defined in the law.

If the board and the council are constituted properly, conflicting interests and preferences may be institutionalized in the AHEC creating a tension that may require that creative problem solving become a way of life for the director in order to bring an AHEC consensus to the negotiation with the medical school. It is important to the process of negotiation that the AHEC director be able to present the collaborated result of the board - council interaction as a single set of trading positions.

The AHEC director must provide leadership to the board while it determines its programmatic priorities not only to ensure that they are addressable within the context of the enabling legislation, but also to incorporate the various interests on the board in a manner acceptable to each board member. There are methods that AHEC

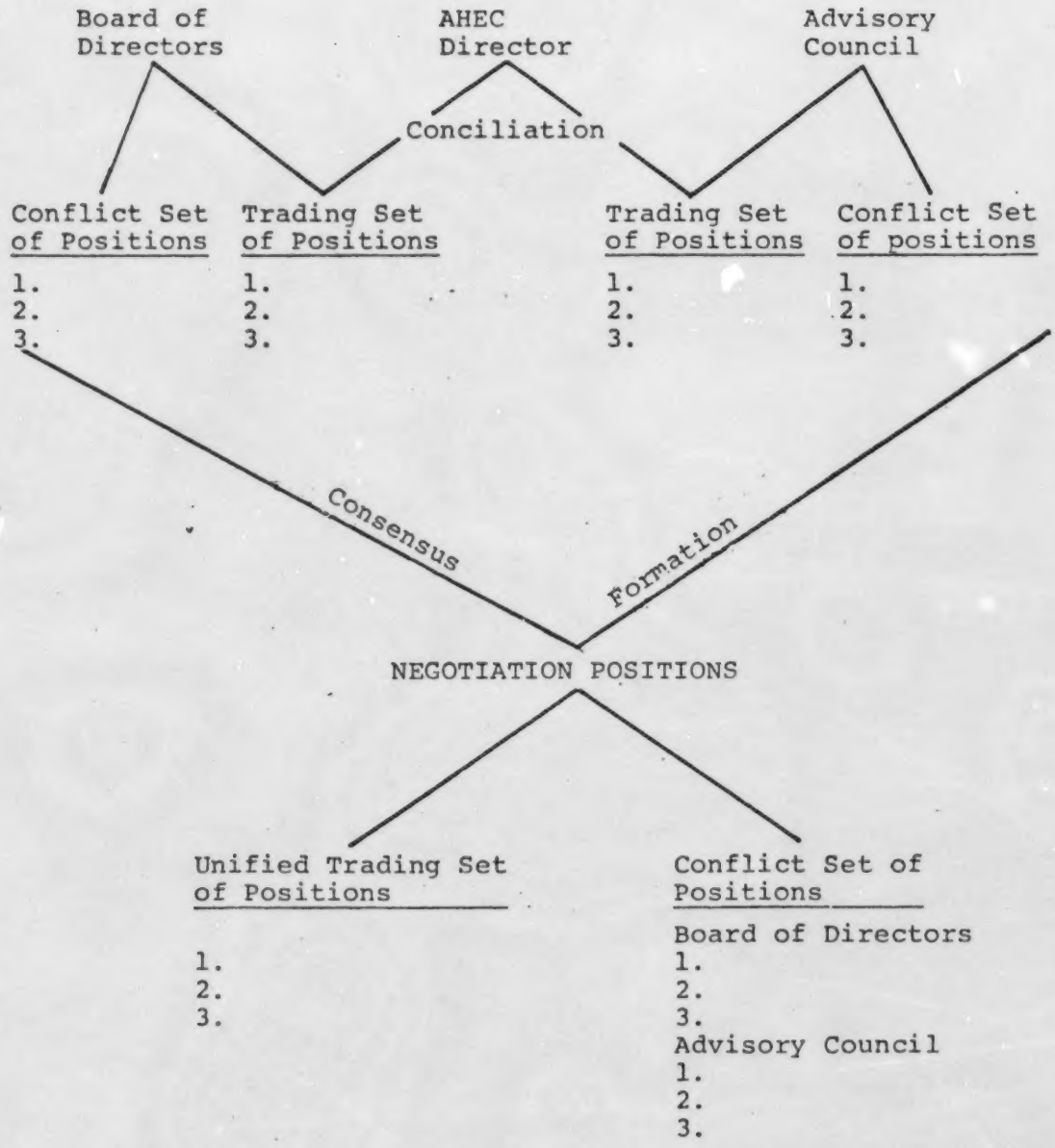
directors may use to gain this consensus but they are not to be addressed here.

The advisory council has a right to advance its positions to the AHEC director although the director is not bound to follow its advice. The poor, therefore, are visible but only in an advisory capacity. However, if the AHEC director is committed to the goals of the law and skilled in consensus formation, the advisory council will play an important role in the development of priorities and programs to address them.

The AHEC is a less defined behavior unit than the medical school and, consequently, more volatile. Conciliation, therefore, is an important goal for the AHEC director and one that must be pursued practically. Furthermore, the AHEC is necessarily less experienced than the medical school in medical education. Thus the board of directors and the advisory council have to be oriented to medical education and, to a lesser degree, the jargon developed by medical educators.

AHEC CONSENSUS

MODEL



The AHEC's role of representing the needs of the medically underserved is tenuous and under interminable stress. This stress at once is induced by the board of directors, if membership is not open to the medically underserved, and by the medical school which may want to absorb elements of the AHEC into its policy determining structure. This cooptation might be easier and more beneficial for the medical school than opposing the AHEC's strongest elements.

The AHEC Director

> "Observe due measure, for right timing is in all things the most important factor."
>
> -Hesiod
> Works and Days 700 B.C.

The AHEC director, as we have seen is required to orchestrate the formation of a consensus from the various points of view that exist within the AHEC governance and advisory structures. This process is crucial to the presentation of a strong position during negotiation with the medical school.

It is important to note that the more divergent the interests within the AHEC the more fragile is the consensus. The more fragile the consensus, it must follow, the more the AHEC director must serve as a conciliator. The AHEC director should view conciliation as a major and personal process goal because conciliation engenders the conciliator with trust and leadership in the organization. If the role of the conciliator is played by a board member or an outsider and not, in either case, in collaboration with the director, a power center probably will emerge that is potentially a threat

to the chief executive officer - the AHEC director.

The AHEC director has conciliation as a function within the AHEC and without; the director must acknowledge these functions as major responsibilities if a strong interrelationship with the medical school is to be gained.

Kenneth Boulding defines the function of pure conciliation as being, "Simply to see that trading opportunities are not missed in the existing field of conflict through ignorance and a failure of communication; the conciliator, in this sense, is a broker, bringing the two parties together; that is, the conciliator brings the parties to the contract or conflict curve ..." (Boulding, 1962). This definition may be applied to the AHEC director's role within the AHEC as he or she guides the board and the council to a consensus and it may be applied also to the director's role as the primary negotiator with the medical school.

Communication is the most important feature of negotiation. In the instance of AHEC and medical school negotiation, the AHEC director must be bilingual, equally conversant in the language of medical education and the language of the organization's constituents. An AHEC director who is bilingual and conciliatory will be received well by the AHEC's constituents and the medical school. The opportunity to persuade the medical school to adopt alternatives most suitable to the AHEC will be obvious.

There is a clear danger to the process of negotiation if the chief executive officer loses sight of his or her conciliatory role. If the conciliator does not communicate the trading sets of positions effectively, the process of negotiation is subverted and a major conflict follows.

Conciliation by the director should persist throughout the process of negotiation because the parties must remain aware of each other's conflict and trading sets of positions and the shifts that occur within them so that they may move for closure at the appropriate time. Although conciliatory gesturing must persist, the AHEC director must articulate clearly and strongly the perceived and real needs of his or her constituents.

The AHEC director must understand the history of the particular medical school with which the center will negotiate. This history usually is not written but it can be learned by careful listening to and comparing the perceptions of the school's administration and faculty and community members.

The AHEC director must become familiar with the specific professional needs of the regional director because these needs are inseparable from the needs of the school (they are easier to view because of their specificity), and they will be addressed vigorously during the process of negotiation.

The AHEC director should list the conflict and trading sets of positions for the medical school not losing sight of the bargaining field. The lists will be similar to the following.

Conflict set of positions	Trading set of positions
1. control of faculty (clinical appointments)	1. location of training sites
2. control of curriculum	2. curriculum enhancements (learning opportunities)
3. control of institutional resources	3. purchases of faculty time
4. control of students' experiences	4. center's emphasis (nutrition, geriatrics)
	5. independent documentation of community involvement
	6. support for regional director's agenda

Conclusion

Negotiation is a process and, equally, it is an art. Most of us who are placed in the role of negotiator have only a casual appreciation for the demands it places on our ability to maintain a productive perspective and move two parties from an adversary relationship to one of collaboration and reciprocity.

What makes the negotiation worthwhile? There are two answers to this question: The satisfaction of seeing movement toward the organization's highly valued goals and the satisfaction of making the process work.

A skilled negotiator can help Doctor Foster and the people of Gloucester come to grips with their differences to the point where they will collaborate on their shared goals. That skilled negotiator knows, among other things, that Hippocrates was right when he said that, "Healing is a matter of time, but it is sometimes also a matter of opportunity." Thus the AHEC director must view the dialogue of negotiation as one that creates opportunities for needs to be met in a collaborative fashion and, most importantly, for the healing of our deep social wounds.

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